

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6981

State File No.

Registrar's No.

BIRTH NO.		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 3063		State File No.		Registrar's No. 578	
1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY St. Louis					
b. CITY (If outside corporate limits, write RURAL and give township) Clayton				c. LENGTH OF STAY (in this place) D.O.A.		c. CITY (If outside corporate limits, write RURAL and give township) University City			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hospt.				d. STREET ADDRESS (If rural, give location) 7557 Ahern					
3. NAME OF DECEASED (Type or Print) a. (First) OSCAR b. (Middle) S c. (Last) SQUIRES				4. DATE OF DEATH (Month) (Day) (Year) Mar. 5 1950					
5. SEX M		6. COLOR OR RACE W.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Apr 28 1885		9. AGE (In years last birthday) 64 If UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Benjamin Squires				13b. MOTHER'S MAIDEN NAME Hannah Campbell		14. NAME OF HUSBAND OR WIFE Lillian			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI				16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME Lillian Squires ADDRESS 7557 Ahern			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Duodenal peptic ulcer ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Hemorrhage from above II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 7 mo. 5400	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 540.0						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. HOW DID INJURY OCCUR?			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 7:00 m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22. I hereby certify that I attended the deceased from Mar. 4, 1950 , to Mar. 5, 1950 , that I last saw the deceased alive on Mar. 5, 1950 , and that death occurred at 2:00 m., from the causes and on the date stated above.									
23a. SIGNATURE R.R. Cable (Degree or title) M.D.				23b. ADDRESS 601 S. Brentwood, Clayton 5, Mo.		23c. DATE SIGNED 3-6-50			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Mar 8 1950		24c. NAME OF CEMETERY OR CREMATORY Lake Charles		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.			
DATE REC'D BY LOCAL MAR 6 1950		REGISTRAR'S SIGNATURE Herbert W. Donke		25. FUNERAL DIRECTOR'S SIGNATURE Harold 1905 Union		ADDRESS			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.